Life

APPLICATION

PART I - A. PRODUCT INFORMATION

1. Select One: ☐ ReliaStar Life Insurance Company, Home Office: Minneapolis, MN
   ☒ Security Life of Denver Insurance Company, Home Office: Denver, CO
2. Product Requested ING LIFE DESIGN GUARANTEE UL
3. Product Type: ☒ Fixed ☐ Variable *(If applying for a variable life insurance policy, the Owner must receive a current prospectus and a Fund Allocation form must be completed.* **THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS, AND THE CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNTS.)**
4. Base Coverage: $ $10,000,000
   (Not including Term Riders - See Section B for Adjustable Term Insurance Rider.)
5. Death Benefit Option: *(If no option is selected, option will default to A.)*
   ☒ A or 1 - Level ☐ B or 2 - Increasing or Variable
   ☐ C or 3 - Face Amount + Premium ☐ D or 4 - Face Amount + Premium + Interest % _____
6. Death Benefit Qualification Test: *(If no option is selected, option will default to Guideline Premium Test.)*
   ☒ Guideline Premium Test ☐ Cash Value Accumulation Test
7. Is the insurance for a tax-qualified, pension, profit sharing or defined contribution ERISA plan or a VEBA or welfare benefit arrangement? *(If "Yes", complete Section C Appendix A.)* ..... ☐ Yes ☒ No
8. Is the insurance employer sponsored? ..... ☐ Yes ☒ No
9. Please list all applications that are concurrently being submitted to ING for the Insured's family members or business partners.

PART I - B. RIDER INFORMATION

Check appropriate box and enter amounts. (NOT ALL RIDERS ARE AVAILABLE WITH ALL PRODUCTS OR IN ALL STATES.)
Signed illustration is required for permanent products.

☐ Accelerated Benefit Rider/"Living" Benefit Rider
☐ Waiver of Premium *(Term only)*
☐ Waiver of Monthly Deduction or Cost of Insurance Rider
☐ Waiver of Specified Premium Rider
(Specify monthly premium - Illustration required) $ _____
☐ Additional Insured Rider *(on Primary Insured)* $ _____
☐ Other Insured Rider *(on Proposed Other Insured)* $ _____
☐ Accidental Death Benefit Rider $ _____
☐ Joint Additional Insured Rider $ _____
☐ Children's Insurance Rider
(Complete Children's Insurance Rider Application.) $ _____
☐ Guaranteed Death Benefit Rider
☐ Lifetime ☐ 20-Year ☐ To age 65 or 20 years, if later
☐ Term Rider *(Specify)* _____ $ _____
☐ Adjustable Term Insurance Rider
(Specify Target Death Benefit) _____ $ _____
☐ Other _____ $ _____

PART I - C. PROPOSED PRIMARY INSURED INFORMATION

1. First Name Asher MI H Last Name Blumenthal
2. Date of Birth 10/26/33 Sex ☒ M ☐ F SSN 031-42-2780 Birth State/Country ISRAEL
3. Residence Address 1312 42 St Brooklyn NY 11219
   (P.O. Boxes are not permitted, other than APO/FPO) *City* *State* *ZIP*
4. Phone 718 657 5819
5. Are you a U.S. Citizen? *(If "No", complete the Foreign Travel and Residence Questionnaire.)* ..... ☒ Yes ☐ No
6. Occupation/Duties Vice President

7. Employer Being Bros. Vineland NJ

8. Do you currently use or have you ever used tobacco or nicotine products in any form? *(e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum, or nicotine patches)* ☐ Yes ☑ No

If "Yes", indicate Type _____ Amount & Frequency _____ Month/Year Last Used _____

9. Driver's License Number/State: 361 857 194 / NY
(If you do not have one, then provide government photo ID #, issuer and expiration date.)

PART I - D. PROPOSED OTHER INSURED INFORMATION

1. First Name _____ MI _____ Last Name _____

2. Date of Birth _____ Sex ☐ M ☐ F SSN _____ Birth State/Country _____

3. Residence Address _____
(P.O. Boxes are not permitted, other than APO/FPO) *City* *State* *ZIP*

4. Phone _____

5. Are you a U.S. Citizen? *(If "No", complete the Foreign Travel and Residence Questionnaire.)* ☐ Yes ☐ No

6. Occupation/Duties _____

7. Employer _____

8. Do you currently use or have you ever used tobacco or nicotine products in any form? *(e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum, or nicotine patches)* ☐ Yes ☐ No

If "Yes", indicate Type _____ Amount & Frequency _____ Month/Year Last Used _____

9. Driver's License Number/State: _____
(If you do not have one, then provide government photo ID #, issuer and expiration date.)

PART I - E. PERSONAL HISTORY

Questions 1-7 must be completed for all Proposed Insureds.

	Proposed Insured		Proposed Other Insured	
	Yes	No	Yes	No
1. Are you, or do you intend to become a member of the armed forces, including the Reserves, or on alert? *(If "Yes", complete Military Questionnaire.)*	☐	☑	☐	☐
2. Do you intend to travel or reside outside the United States or Canada? *(If "Yes", complete the Foreign Travel and Residence Questionnaire.)*	☐	☑	☐	☐
3. Have you in the last five years made or do you anticipate making flights in an aircraft OTHER than as a passenger on a scheduled airline? *(If "Yes", complete the Aviation Questionnaire.)*	☐	☑	☐	☐
4. Do you participate in hang-gliding, soaring, sky-diving, ballooning, skin or scuba diving, mountain climbing, competitive skiing, rodeos, or any other hazardous sports or activities? *(If "Yes", complete appropriate questionnaire.)*	☐	☑	☐	☐
5. Do you race, test or stunt drive automobiles, motorcycles, motor boats, or jet powered vehicles, or do you use or race snowmobiles, dirt bikes, dune buggies, etc.? *(If "Yes", complete Motorized Vehicle/Powerboat Questionnaire.)*	☐	☑	☐	☐
6. Except for traffic violations, have you been convicted in a criminal proceeding or been the subject of a pending criminal proceeding?	☐	☑	☐	☐
7. Have you in the last five years had any motor vehicle accidents, alcohol or drug related convictions, or other moving violations while operating a motor vehicle?	☐	☑	☐	☐

For any "Yes" answer to questions 6-7, please record information in the chart below.

Ques. #	Person	Explanation

PART I - F. BENEFICIARY INFORMATION

Unless otherwise stated, the beneficiary designation is revocable and beneficiaries of like class shall share rights of survivorship equally. If Trust or Corporation, provide name and date of trust agreement and state of incorporation. Percentages must total 100%, using whole percentages only. If additional space is needed, use Section R.

1. Is the Beneficiary a Trust? ..... ☑ Yes ☐ No

2. Name of Trust ASHER BLUMENTHEL FAMILY TRUST Date of Trust 12/1/07 State of Incorporation NJ

	Name (First, MI, Last)	DOB	SSN	Relationship	%	Beneficiary Type
Proposed Primary Insured	Asher Blumenthal Family Trust	12/1/07	26-6194903	Trust	100	☒ Primary ☐ Contingent
						☐ Primary ☐ Contingent
						☐ Primary ☐ Contingent
						☐ Primary ☐ Contingent
Proposed Other Insured						☐ Primary ☐ Contingent
						☐ Primary ☐ Contingent
						☐ Primary ☐ Contingent
						☐ Primary ☐ Contingent

PART I - G. PROPOSED OWNER/TRUST/CORPORATION INFORMATION

If Proposed Owner is a Trust or Corporation, provide first and last pages of the Trust document, including signatures.

1. Full Name of Owner/Trust/Corporation Asher Blumenthal Trust

2. Owner Relationship to Proposed Primary Insured Trust

3. Owner Date of Birth _____ Owner Phone _____ Owner SSN _____

4. Owner Address _____
(P.O. Boxes are not permitted other than APO/FPO) *City* *State* *ZIP*

5. Address of Trust/Corporation _____

6. Billing Address _____
(P.O. Boxes are not permitted other than APO/FPO) *City* *State* *ZIP*

7. Type of Government Issued ID *(Driver's License/Passport)* _____ Document # _____

Issuing State or Country _____ Date of Issuance _____ Date of Expiration _____

8. Trust Contact Name Moshe Blumenthal Tax ID 26-6194903 Date of Trust 12/1/07

9. Type of Trust: ☐ Revocable ☑ Irrevocable Purpose of the Trust _____

10. State of Incorporation _____ Name of Trustee/Corporate Officer _____

11. Does the above trustee have sole authority to act on behalf of the Trust? ..... ☑ Yes ☐ No
(If "No", list the names & addresses of all trustees on a separate page, and obtain signatures from all trustees on the application.)

PART I - H. FINANCIAL DETAILS

1. Will the applicant accept this policy if it is a "Modified Endowment Contract" at issue? ☐ Yes ☑ No
2. Is the policy in accordance with your insurance objectives and your anticipated financial needs? ☑ Yes ☐ No
3. Do you believe you have the financial ability to continue making premium payments on this policy? ☑ Yes ☐ No
4. Have you or your company ever declared bankruptcy? *(If "Yes", provide details including date discharged.)* ☐ Yes ☑ No
5. Personal Insurance *(For Personal Insurance complete questions 5-7; for Business Insurance complete questions 8-11.)*
   ☑ Estate Liquidity ☐ Family Protection ☐ Tax Planning ☐ Retirement Planning ☐ Cash Accumulation
   ☐ Other _____
6. Insured's Annual Earned Income $650,000 Annual Interest & Other Income Unearned $1.8 million
7. Total Assets $24,250,000 Total Liabilities $1,000,000 Total Net Worth $23,650,000
8. Business Insurance
   ☐ Buy/Sell ☐ Key Person ☐ Other _____
9. Total Assets _____ Total Liabilities _____ Total Net Worth _____
10. Net Profit After Taxes for Past Two Years: Last Year _____ Previous Year _____

11. Name of Owner	Title	Amount of Business Coverage in force	Percentage of Ownership	Active in Business?

PART I - I. IN FORCE/REPLACEMENT INFORMATION

Questions 1-3 must be completed for each Proposed Insured/Other Insured/Owner.

	Proposed Insured Yes	Proposed Insured No	Proposed Other Insured Yes	Proposed Other Insured No	Proposed Owner Yes	Proposed Owner No
1. Do you currently have life insurance inforce or applied for? *(If "Yes", provide details below. Complete state required replacement form for Model Replacement Regulation States ONLY.)*	☐	☑	☐	☐	☐	☒
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? *(If "Yes", complete state required replacement form and provide details below.)*	☐	☑	☐	☐	☐	☑
3. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? *(If "Yes", complete state required replacement form and provide details below.)*	☐	☑	☐	☐	☐	☑

Name of Insured	Insurance Company (Do not include group policies.)	Policy #	Amount	Date Issued

4. Is this insurance intended to be a tax free or 1035 Exchange? *(1035 not available on term insurance)* ☐ Yes ☑ No
5. If "Yes", will a policy loan be carried over? ☐ Yes ☐ No

PART I - J. PAYMENT INFORMATION

1. Special Dating Request: ☐ Date to Save Age ☐ Specific Date Month _____ Day _____ Year _____.
   (Other than the 29th, 30th, or 31st.)
2. Initial Payment: ☐ Check ☐ COD ☐ 1035 Exchange ☐ ING Internal or Affiliated Exchange/Surrender
3. Mode of Payment: ☑ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly *(Complete EFT form-Appendix E.)*
   ☐ Military Allotment *(Active or retired military members must complete Military Allotment form and return to the Military finance department.)*
   ☐ Civil Service Allotment *(Federal Civil Service Application Checklist, Bank Allotment Authority, and Employer 1199 for Direct Deposit must be completed.)*
4. Initial Payment Amount $ 449,340 Planned/Scheduled/Modal Payment $ 449,340

PART I - K. MEDICAL TRANSFER STATEMENT

Complete when submitting medical examinations of another insurance company.

1. Name of Insurance Company _____ 2. Date of Examination _____

	Proposed Insured		Proposed Other Insured	
	Yes	No	Yes	No
3. To the best of your knowledge and belief, are the statements in the examination true and complete today?	☐	☐	☐	☐
4. Have you consulted a medical doctor or other practitioner since the examination indicated in question 1 above? *(If "Yes", complete Part II - Medical Declarations.)*	☐	☐	☐	☐

PART I - L. LIST BILL INFORMATION *(For Employer-Sponsored Plans ONLY)*

For a new List Bill Plan, please contact the List Bill Department at 877-886-5050.

1. List Bill/File Code # *(if plan already exists)* | | | | | | | | | | |
2. Employer Plan Name *(if plan already exists)* _____
3. Phone _____
4. Address _____
Street Address *City* *State* *ZIP*

PART I - M. AUTOMATIC TELEPHONE PRIVILEGES *(Complete for Variable Products ONLY)*

I understand that unless I decline, telephone privileges are automatically provided to me, my agent/registered representative, and his/her assistant. Telephone privileges allow an authorized person to call the Company to perform certain transactions as specified in the current prospectus. The Company may use procedures to ensure instructions received by telephone are genuine, such as requiring forms of personal identification and tape recording phone calls. The Company and its distributor will not be liable for any loss, damage, costs or expenses incurred in acting on telephone instructions reasonably believed to be authentic. I understand that if I do not want to authorize telephone privileges, I must indicate below. I also understand that once granted, such privileges can be revoked only upon receipt of signed, written instructions at the Company.

☐ I do not want telephone privileges.

☐ I do not want telephone privileges granted to my agent/registered representative and his/her assistant.

PART I - N. SUITABILITY/NEEDS ANALYSIS *(Proposed Owner to complete for Variable Products ONLY)*

1. Have you received a current prospectus including supplements for the variable life insurance policy and each of the Variable Account Investment Options? ☐ Yes ☐ No

Provide date of policy prospectus/supplement _____

2. Do you understand that: The amount or duration of the policy death benefit may vary under specified conditions; Policy values may increase or decrease with the investment experience of the investment options; Policy values may also increase with the interest credited in the Guaranteed Interest Division; The amount payable at the final policy date is not guaranteed, but is dependent on the account value and amounts owed under the policy at that time? ☐ Yes ☐ No
3. Do you understand that the fluctuation in values under the policy means that scheduled premium payments may not be sufficient to keep the policy in force in the event of market declines? ☐ Yes ☐ No
4. Do you understand that personalized illustrations are based on hypothetical rates of return which may not be indicative of future investment experience or of actual interest credited in the Guaranteed Interest Division? ☐ Yes ☐ No

PART I - O. REPLACEMENT VERIFICATION *(For Agent use ONLY)*

1. To the best of your knowledge and belief, will any existing life or annuity coverage be replaced, lapsed, surrendered, or borrowed against? *(If "Yes", submit state required replacement forms.)* ☐ Yes ☑ No
   a. Is the applicant considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating their existing policy or contract? *(If "Yes", complete state required replacement form and provide details below.)* ☐ Yes ☑ No
   b. Is the applicant considering using funds from their existing policies or contracts to pay premiums due on the new policy or contract? *(If "Yes", complete state required replacement form.)* ☐ Yes ☑ No

Company _____ Policy # _____ Amount _____

PART I - P. IMPORTANT INFORMATION

To help the government fight the funding for terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: When you apply for life insurance, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

If you wish to have a more detailed explanation of our information practices, please write to us at: Individual Life Underwriting, ReliaStar Life Insurance Company, Home Office: Minneapolis, MN, Administrative Office, ING Service Center, P.O. Box 5075, Minot, ND, 58702-5075 or Individual Life Underwriting, Security Life of Denver Insurance Company, Home Office: Denver, CO, Administrative Office, ING Service Center, P.O. Box 5065, Minot, ND, 58702-5065.

Notice to Applicants Regarding Policy Dating Procedures: Your policy will be dated either on the date that it is issued or on a date that you specifically request. Within certain limits, you may choose a date that is before or after the date of your application. The policy date governs many of the duties and obligations under this policy including when renewal premiums are due. If the policy date is prior to the in force date, premiums will be based on the policy date.

There are a number of reasons why you might request a specific policy date, such as:

- To obtain a lower premium if a date before the date of issue would result in a lower insurance age.
- To obtain a savings in premium by selecting a future policy date, since premiums are billed from the policy date.
- To coincide with other elements of an estate plan.
- To provide a preselected convenient date as the due date for premiums.

Policy dating for applicants who pay the premium when the policy is delivered or who are required to pay additional premium upon delivery only: You may decide at the time of policy delivery to change the date of your policy to the delivery date. The Policy Delivery Receipt included with your policy will contain instructions for changing the policy date to the delivery date. Changing the policy date to the date of delivery may result in an increase in your premium as a result of a change in insurance age. If so, you will be notified by the Company and you may then decide not to have the policy redated.

The Company does not accept premium payments or loan repayments using money orders for amounts over $5000.00 and may reject payments made by cashier's checks, bank drafts, bank checks and treasurer's checks. All premium checks must be made payable to ReliaStar Life Insurance Company or Security Life of Denver Insurance Company.

PART I - Q. STATE REQUIRED NOTICE

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

This page must be given to the Proposed Insured.

PART I - R. NOTES

Use this space to provide any additional details to questions answered throughout the application. Please understand that if you provide the Company with information on this page it will be considered part of your Application for Life Insurance.

Section	Question #	Details

PART I - S. AUTHORIZATION AND ACKNOWLEDGEMENT

The undersigned Proposed Insured(s) declares: By completing this life insurance application, I understand that I am applying for life insurance coverage which may be issued by one or more of the ING life companies. These include ReliaStar Life Insurance Company or Security Life of Denver Insurance Company, referred to individually or collectively as the "Company." I understand and consent that this application and information obtained pursuant to this authorization may be used by the Company to evaluate my eligibility for life insurance. For underwriting and claims purposes, I authorize any physician, medical practitioner, hospital, clinic or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc. ("MIB"), any consumer reporting agency, or any other organization to release to the Company or their authorized representatives (including any consumer reporting agency) acting on their behalf, ALL INFORMATION requested by the Company about me and any minor children who are to be insured. This includes but is not limited to: Any medical information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and treatment of me or my minor children who are to be insured; Prescription drug records and related information maintained by physicians, pharmacy benefit managers and other sources; Any non-medical information about me or my minor children who are to be insured. By this authorization, each physician, medical practitioner, hospital, clinic or medically related facility contacted by the Company is instructed to provide the entire medical record in its possession concerning me or any minor children who are to be insured.

- I give my permission to the Company to collect consumer or investigative consumer reports about these same persons.
- I give my permission to the Company and other insurance companies affiliated with the Company to collect any and all medical record information for the purposes described in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations - 42CFR Part 2. I may revoke this permission and authorization as it applies to any information protected by 42CFR Part 2 or by applicable state law at any time by mailing the written revocation to the Company at the address on the Consumer Privacy Notice, but not to the extent action has been taken. I understand that the release of medical records will not be requested with respect to tests performed to determine the presence of the Human Immunodeficiency Virus (HIV) antibody.

For any life insurance application or other insurance transaction that I may have with the Company, I specifically consent that some or all of the information obtained by this authorization may be sent to MIB, reinsurers, the agent who solicited my application and his or her principals, employees or contractors who process transactions regarding any insurance coverage I may have applied for or have with the Company or affiliated companies. I understand the information obtained by use of the Authorization will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing policy.

- **I understand that I may request to be interviewed if an investigative consumer report is prepared. You may contact me between the hours of _____ am/pm and _____ am/pm. My daytime telephone number is (_____) _____.**
- **I know that I have a right to receive a copy of this form and a photocopy will be as valid as the original.**
- **This form will be valid for 24 months from the date shown below.**
- **I acknowledge receipt of the following notices: Notice Regarding Consumer Reports; Notice Regarding MIB; and Notice Regarding Information Practices.**

VERIFICATION:
Each of the undersigned also declares that:

A. I have read the statements and answers given in this application and affirm that they are true and complete to the best of my knowledge and belief. I understand that the Company may seek to rescind or cancel the insurance coverage if there is any material misrepresentation.

B. This application consists of Part I, Part II, and supplemental questionnaires, and will be the basis for any coverage issued on this application. Any coverage issued on this application will take effect only upon satisfaction of all of the Company's requirements, except as otherwise provided in the Conditional Receipt, if issued, with the same date as this application. Except where permitted expressly by statute or regulation, no agent or medical examiner has the authority to waive the answer to any question in the application, to pass on insurability, to make or alter any contract or waive any of the Company's rights or requirements.

C. I certify, under penalty of perjury, that my Social Security/tax identification number(s) is(are) shown and is(are) correct and that I am not subject to back-up withholding.

All completed materials must be sent to the Administrative Office at: ING Service Center, 2000 21st Ave. NW, Minot, ND 58703

Signed at: *(city/state)* Ramsey, NJ Date 1/11/08

X Signature of Proposed Insured *(if age 15 or older)* A. Blumenthal Date 1/11/08

X Signature of Proposed Other Insured _____ Date _____

X Signature of Proposed Owner *(if other than the Insured)* _____ Date 1/11/08

Print Proposed Owner/Trustee Name Moshe Blumenthal

X Signature of Parent or Guardian *(if the Proposed Owner or the Proposed Primary Insured is a minor)* _____

X Signature of Writing Agent/Registered Rep. M. Nkff

Writing Agent State Lic. # NA-541295 Writing Agent/Registered Rep. # 177113

Name of Agent/Registered Rep. Nachman Minkoff

Agent State Lic. # _____ Agent/Registered Rep. # _____

Name of Agent/Registered Rep. _____

Agent State Lic. # _____ Agent/Registered Rep. # _____

Life

AGENT'S REPORT

To be completed by the Agent. For questions about this application or requirements, contact the underwriting department.

Agent Name/Broker Dealer (Please Print.)	Agent ID #	% Split	General Agent #	General Agent Name
Maehmen Minkoff	127113	100	159330	Liberty Planning, Inc

A. COMPLIANCE INFORMATION

1. Did you obtain the Proposed Insured's Medical Declarations in person and record them in the presence of the Proposed Insured? *(If "No", explain why and arrange for an exam.)* ☑ Yes ☐ No
2. Have you delivered the Consumer Privacy Notice to the Proposed Insured(s) or Proposed Owner? ☑ Yes ☐ No
3. Did you meet personally with the applicant/owner and review their Government issued ID? *(If "No", explain below.)* ☑ Yes ☐ No
4. If premium was accepted, was the Conditional Receipt completed and delivered to the Proposed Insured or Proposed Owner? ☐ Yes ☐ No
5. All sales materials used during the sale process were approved by the insurer. The following are the approved sales materials used in my sales presentation: _____
6. Copies of all sales materials were left with the applicant no later than the time of application. (Electronically presented sales materials will be provided to the policyowner no later than at the time of the policy delivery.) Our Company requires that all replacement sales are made in accordance with the Company's corporate policy. If this particular sale is NOT in accordance with the Company's corporate replacement policy, please check here ☐ and attach an explanation.
7. Will there be a rebate of any kind, such as a rebate of premium, to the Proposed Insured or Proposed Owner? ☐ Yes ☑ No
8. To your knowledge, does the Owner intend to change ownership of the policy after its issuance *(i.e. to a trust, viatical or life settlement company or other person)*? ☐ Yes ☑ No
9. Will any portion of the premiums for this policy be financed? ☐ Yes ☑ No

B. PROPOSED INSURED/OWNER INFORMATION

1. How long have you known the Proposed Insured? 7 yrs.
2. Are you related? ☐ Yes ☑ No How? _____
3. How much insurance does the Proposed Insured's spouse own payable to the Proposed Insured or other dependents? $ _____
4. If this application is for a juvenile, please indicate the amount of life insurance in force on each parent or sibling.
   Father $ _____ Mother $ _____ Sibling $ _____
5. Please check the Underwriting requirements ordered: ☒ Blood Profile/HOS ☐ Inspection Report ☑ MD Exam
   ☐ Treadmill EKG ☑ EKG ☐ Paramedical Exam Paramed Company _____

C. FUNDED ERISA PLAN INFORMATION

If the policy will be owned by a "Funded ERISA Plan", you must specify the plan and trust type by checking the appropriate box below and provide the other information requested.

Name of Plan Provider _____

☐ Tax-qualified plan *(specify profit sharing, defined benefit, or defined contribution)* _____

☐ Section 419/419A(f)(6) welfare benefit or VEBA plan

☐ Other *(specify type and name of plan)* _____

D. REMARKS

Use this area to request alternates/optionals, including the selection of alternative commission structures, where available.

E. ACKNOWLEDGEMENT

By signing below, I acknowledge my receipt and acceptance of the terms of the current ING Life Companies General Agent or Producer Agreement ("Agreement"), whichever is applicable, including but not limited to any compensation schedules. I agree to be bound by the terms and conditions of that Agreement, unless I am an employee/registered representative of a Broker/Dealer and do not hold an Agreement such that this language is inapplicable.

I understand that I may receive an additional copy of my Agreement and/or current compensation schedule, from the Company, by contacting Distributor Services at 877-882-5050.

F. AGENT SIGNATURE

Agent Signature(s) _____ Date 1/11/08

Contact for Requirements _____ Agent SSN 056 66 7562

Agent Phone 917 783 9703 Fax 718 854 1891 Email Address 9r8ins@yahoo.com

Life

CONSUMER PRIVACY NOTICE

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. The agency that makes the report will be one that is discreet and impartial. If you wish, we will send you the name, address and telephone number of any agency we ask to prepare a consumer report about you. You can request that the agency interview you. This may be indicated on the authorization form.

Consumer reports are used to help us decide if you are eligible for the insurance for which you have applied. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocations, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, by contacting you, members of your family, business associates and employers, financial sources, and friends or others you know. This information will not be used to determine your sexual orientation. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with ReliaStar Life Insurance Company or Security Life of Denver Insurance Company (the "Company"). You may request that this information not be communicated to other companies affiliated with the Company.

The information may be kept by the consumer reporting agency. It may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; and your state's Insurance Information and Privacy Protection Act, if any. The agency will give you a copy of the report if you ask for one and provide the proper identification.

Notice Regarding MIB (Medical Information Bureau, Inc.)

We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested.

MIB is a nonprofit organization of life insurance companies. It operates as an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask MIB, it will arrange to disclose to you the information it has in your file. If you question the accuracy of the information in MIB's file, you may contact MIB to seek correction, as provided in the Federal Fair Credit Reporting Act. The address of MIB's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02112. MIB's phone number is (617) 426-3660.

We or our reinsurers may also release information in our files. We may release it to other life insurance companies to which you may apply for life or health insurance or to which a claim for benefits may be submitted upon request.

Notice Regarding Information Practices

To issue an insurance policy, we need to obtain information about you and any other persons proposed for insurance. Some of that information will come from you. Some will come from other sources. That information and any information collected by us later may, in certain circumstances, be disclosed to third parties without your specific permission.

You have a right to access and correct the information collected about you. This right does not extend to information that relates to a claim or civil or criminal proceeding. You have the right to receive, in writing, the reasons for any adverse underwriting decisions.

This page must be given to the Proposed Insured.